

October 13, 2020

Congressman Vaupel

**Re: Support of Senate Bill 0826**

Dear Congressman Vaupel and members of the House Health Policy Committee,

Thank you for the opportunity to speak in support of Bill 826 today.

The Public Health Code and the Mental Health Code were written for the benefit of patients, not providers. The purpose of Bill 826 is to update the Mental Health Code to align with the Public Health Code by including physician assistants (PAs) and nurse practitioners (NPs) in order to increase mental health consumers' access to safe care. What is important to understand here is that it is not the mental health PA or NP who has decreased privilege. It is the mental health consumer who has decreased access to safe treatment, because the measures put in place to protect patients and their communities exclude a growing body of much needed mental health providers.

The Public Health Code includes these advance practice professionals (APPs,) but the Mental Health Code (MHC) names only psychiatrists and resident psychiatrists as those who can write clinical certifications or order restraints for patients. We have a significant shortage of psychiatrists in our state, and an increasing number of Michiganders seeking care for mental illness and substance abuse. More and more APPs are responding to the need, but excluding these highly trained and skilled providers from the MHC only serves to perpetuate the barrier to care and safety faced by individuals with mental illness. The same APPs who cannot write certifications or order restraints for mental health consumers, can and do for patients receiving medical care, because those patients are covered by the Public Health Code rather than the Mental Health Code. In other words, if I walk off the inpatient psychiatric unit where I work, and onto a medical unit, I can order restraints to maintain the safety of a delirious patient for whom

I am providing medical care. Yet I cannot restrain a psychotic patient who presents a danger to himself or other patients or staff on the psychiatric unit.

I work every day with severely ill individuals - psychotic patients, personality disordered patients with behavioral disturbances, and developmentally delayed patients, often whose illness symptoms put them at risk for self harm or put others at risk for harm. In such situations, physical restraint is sometimes the least restrictive safety measure. Per the current MHC, nurses can temporarily place an unsafe patient in restraints, but must obtain a restraint order from a psychiatrist within 30 minutes, and the patient must be seen by a psychiatrist within 60 minutes. If either of these timelines cannot be met, the restraint must be removed in accordance with patients' rights, leaving the patient and staff at risk for serious harm. I often work with psychiatrists who are busy elsewhere on the hospital campus, and unable to see a patient within the required 30 minutes after going into restraint. If my patient and staff must await the arrival of a psychiatrist to perform a face to face evaluation, though I am present and familiar with the patient's illness and treatment needs, it can prolong the patient's distress and subsequently their risk for harm, as well as the risk for harm to others around them. If an available psychiatrist is not familiar to the patient who is already in distress, that distress can escalate further, again increasing risk and potentially prolonging the time in restraint, and also the likelihood of needing additional medication. It can also damage or destroy any alignment or rapport staff and I have built with the patient - and with their family.

Recently a critically ill geriatric patient came to my team in need of treatment for severe depression. Her illness had worsened to the point she had become psychotic, subsequently causing such a decline in function that she had stopped eating, drinking, or otherwise caring for herself. Thus she was also medically frail and in need of basic medical care as well as treatment for her psychotic depression. She was too ill to voluntarily sign herself in for treatment and she required certification for admission. She had been transferred directly from a small hospital in rural Michigan, and came alone via ambulance. The discharging hospital had a delay in getting her out, and by the time she arrived, her certification had expired. The psychiatrists on the unit had been called to meet various needs elsewhere in the hospital, and as a PA, I could not write a new certification, without which I could not admit her. I could not order her medications, or IV fluids. I could not even give her a bed to lie down on, because I could not bring her

onto the inpatient psych unit without a certification. While a certification is a necessary step in protecting patient rights, because I could not provide that protection, this frail, trembling, frightened elderly woman waited alone outside the inpatient unit, while I looked for a psychiatrist to come write her certification.

I wanted to share patient experiences with you to illustrate the need for increased access to care, and to emphasize that the goal of updating the mental health code is not to expand APPs' practice or privilege, but rather to ensure access for all to safe and timely treatment.

Thank you again on behalf of Michigan's mental health patients, their families, and those of us who treat them.

Sincerely,

Alison Badger, PA-C, CAQ Psychiatry, Michigan Medicine